Supreme Court, U.S.
FILED

No. 95-1118 JAN 11 1996

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1995

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN and COMPCARE HEALTH SERVICES INSURANCE CORPORATION,

Petitioners,

v.

THE MARSHFIELD CLINIC and SECURITY HEALTH PLAN OF WISCONSIN, INC.,

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether, in a case involving a market-dominant physician-owned "health maintenance organization" ("HMO") that had extraordinarily high prices and profits, engaged in geographic division of markets, faced no significant HMO competition, and had effectively excluded a potential competitor that would have lowered HMO prices by twenty percent, the Seventh Circuit correctly overturned a jury finding of monopolization based on the court's view that there is no separate product market for "HMO services."

2. Whether, in a case where affiliation agreements between a market-dominant physician-owned HMO and nearly all of the region's remaining physicians required such physicians to reduce their lucrative compensation from the dominant HMO if they accepted lower offers from another HMO, and those agreements were buttressed by numerous other predatory and concerted actions designed to maintain the dominant HMO's market position, the Seventh Circuit correctly overturned jury findings of monopolization and conspiracy to monopolize based primarily on the court's preconceived views regarding economics and competition.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
TABLE OF AUTHORITIES	iv
OPINIONS BELOW	2
JURISDICTION	2
STATUTES INVOLVED	2
STATEMENT	2
REASONS FOR GRANTING THE WRIT	8
I. THE SEVENTH CIRCUIT'S KEY RULINGS CONSTITUTE BROADLY APPLICABLE GENERALIZATIONS ABOUT THE ECONOMICS OF THE HEALTH-CARE SYSTEM NOT LIMITED TO A PARTICULAR FACTUAL CONTEXT	10
II. THE SEVENTH CIRCUIT'S RULINGS ARE WRONG, BOTH AS A GENERAL MATTER AND AS APPLIED TO THIS CASE	13
1. The HMO Market Issue	13
2. The Issue of the Affiliation Agreements and Related Actions Aimed at Precluding HMO Access to Independent Physicians	18
III. THESE RULINGS WARRANT REVIEW BECAUSE OF THEIR POTENTIAL IMPACT ON THE FUTURE SHAPE OF THE HEALTH-CARE SYSTEM	23
CONCLUSION	29

TABLE OF AUTHORITIES

CASES — Page

Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982) 28
Brooke Group Ltd. v. Brown & Williamson Tobacco Corp., 113 S. Ct. 2578 (1993) 22
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Pub. L. No. 104-18 (1995) 24

TABLE OF AUTHORITIES—Continued

	Page
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TABLE OF AUTHORITIES—Continued

Page

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	Page
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Page

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PETITION FOR A WRIT OF CERTIORARI

Petitioners Blue Cross & Blue Shield United of Wisconsin ("Blue Cross") and Compcare Health Services Insurance Corporation ("Compcare") seek review of a decision of the United States Court of Appeals for the Seventh Circuit vacating most of an antitrust judgment entered in their favor after a jury trial.[1]

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[1] All parties in the court below are listed in the caption. Blue Cross and Blue Shield United of Wisconsin is a Wisconsin corporation with a partial ownership interest in United Wisconsin Services, Inc., a publicly traded Wisconsin company. Compcare Health Services Insurance Corporation, a Wisconsin company, is wholly owned by United Wisconsin Services, Inc.

OPINIONS BELOW

The opinion of the Court of Appeals, as modified on rehearing, is reported at 65 F.3d 1406 (7th Cir. 1995), and, as first issued, is reproduced at Pet. App. 1a. The order denying rehearing but modifying the opinion is reproduced at Pet. App. 64a.

The memorandum opinion and order of the District Court, granting in part and denying in part defendants' motion for judgment as a matter of law, denying defendants' motion for a new trial on liability, denying defendants' motion for a new trial on damages conditioned upon plaintiffs' acceptance of a remittitur, and granting plaintiffs injunctive relief, is reported at 883 F. Supp. 1247 (W.D. Wis. 1995), and is reproduced at Pet. App. 21a.

JURISDICTION

The decision of the court of appeals was issued on September 18, 1995. The order of the court of appeals, denying the request for rehearing but modifying the original opinion, was issued on October 13, 1995. The Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1-2, are reproduced at Pet. App. 77a.

STATEMENT

This is an action under Sections 1 and 2 of the Sherman Act in which the jury found that respondent, The Marshfield Clinic ("Marshfield"), engaged in a wide range of unlawful monopolistic and conspiratorial conduct in furtherance of its corporate mission of becoming "*the* health care system for Wisconsin and Michigan's upper peninsula."[2] The evidence at trial showed that

[2] Trial Exhibit ("Tr. Exh.") 1983 (emphasis in original). This goal was stated in a corporate "mission statement" adopted by Marshfield on February 17, 1987. Fritz Wenzel, Marshfield's Execu-

Marshfield had substantially achieved its goal. Marshfield Clinic itself employs more than 400 physicians in 22 sites throughout north-central Wisconsin. (Pet. App. 2a.) Its HMO—Security Health Plan of Wisconsin, Inc. ("Security")—has 90 percent of the HMO enrollees in nine Wisconsin counties. (Pet. App. 3a, 18a, 27a.) Security has affiliation agreements with 900 physicians, who constitute virtually all the remaining physicians in the region not employed by Marshfield. (*See* Tr. 746-50; Tr. Exh. 10222, 10344-52.) In fact, *all* of the physicians in 13 cities and two entire counties are either Marshfield employees or Security affiliates. (*See* Tr. 713-15.) Finally, Marshfield owns, or controls through its partner Ministry Corporation, seven hospitals, including the largest in the region. (Tr. 195-96.)

Petitioner Compcare, a subsidiary of petitioner Blue Cross, is an HMO that found out how aggressively and effectively Marshfield protects its dominant position. Compcare is typical of the HMOs that are restructuring the national health-care system. It offers consumers a significantly different package of benefits from traditional health insurance plans, and its substantially different cost structure permits it to charge a significantly lower price than traditional health insurers. (Pet. App. 24a-25a; *see also* Tr. 63-64, 70, 343-44, 699-711, 1114-20, 1142-43.) Compcare saw an excellent opportunity to expand into Marshfield's territory, where Security faced no HMO competition and therefore charged far more than an HMO would normally charge, resulting in bloated profits.[3]

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tive Director, acknowledged at trial it was his view that health care should be a monopoly. Trial Transcript ("Tr.") 1362. Marshfield operates as a tax-exempt organization and is one of the largest clinics in the United States with annual revenues of nearly a quarter of a billion dollars. (Pet. App. 2a; *see also* Tr. 711.)

[3] Marshfield's physician prices exceeded statewide averages by 30% (Tr. 132, 151; Tr. Exh. 53) and exceeded those of 90% of all other physicians in the State of Wisconsin (Tr. 127-30, 160-71, 766-69; Tr. Exh. 59). Security, though licensed as an HMO, priced

Marshfield was aware that Compcare intended to charge HMO subscribers substantially less than Marshfield or Security charges. (Tr. Exh. 1562.) Marshfield recognized that a new HMO competitor, if it could obtain participation of Marshfield's physicians, could immediately undercut Security's prices by twenty percent. (*Id.*)

Compcare, however, failed in its attempts to break Security's hold as the dominant provider of HMO services in north-central Wisconsin. (Pet. App. 27a-28a; *see also* Tr. 71, 102, 112-20, 311-13, 1116-17; Tr. Exh. 44, 1156, 1226, 1229, 1295, 1301, 1883.) When Compcare tried to enlist Marshfield and other physicians or hospitals in the region to provide services to its potential HMO subscribers, it was completely unable to do so. (Pet. App. 27a-28a; *see also* Tr. 597, 599-602, 621.) Marshfield's own 400 physicians were unavailable on reasonable terms. (*Id.*) And Marshfield had taken steps to minimize the effects of potential competition from other physicians by making these physicians "affiliates" of Security.

Marshfield induced independent physicians to affiliate with Security by using a "carrot and stick" approach. First, the affiliation agreements offered by Security are unusually lucrative for the physicians involved. (Pet. App. 36a.) Unlike the usual HMO affiliation agreements in competitive markets, the Security agreements provide that affiliated physicians will be compensated for services provided to Security subscribers *at their usual fee rates*—so long as the affiliated physicians further agree to a "most favored nation" ("MFN") clause preventing them from receiving *less* from any other patient or health plan. (Pet. App. 16a-17a, 36a.) This arrangement creates a huge disincentive for physicians to affiliate with other HMOs seeking to pay, and ultimately to charge, at competitive rates, because physicians who affiliate with such HMOs must give up the higher compensation available from Security.

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its HMO product 15% to 75% above comparable products in the State and Nation. (Tr. 1119-22.)

At the same time, Marshfield made it clear that physicians who refuse to affiliate will face ruinous competition, problems with maintaining staff privileges in the region's hospitals, and problems obtaining cross-coverage of patients from other physicians. (Pet. App. 13a, 28a, 33a.) As noted, Marshfield owns or has partnerships with most of the hospitals in the region, which enables it to eliminate competition with Marshfield and to control the ability of unaffiliated physicians to gain staff privileges in those hospitals. (Pet. App. 31a, 33a; *see also* Tr. 58, 201-16, 483, 713, 925-28.)

The evidence at trial also showed that Security used even more direct methods to prevent HMO or physician competition.[4] Some affiliation agreements even expressly barred other clinics from participating in other HMOs. (Pet. App. 36a-37a, 48a-49a; *see also* Tr. 712-13, 856-57, 865-71, 1361-62.) And when Security faced competition from one smaller HMO (NCHPP) on the edge of its region, it agreed to a geographic division of markets—allowing NCHPP to dominate in the two counties where it was currently based so long as NCHPP did not expand into the neighboring counties (on three sides) where Security was the dominant HMO. (Pet. App. 17a-18a, 48a-49a; *see also* Tr. 856-57, 865-66, 870-71.)[5]

Security is able to make generous financial arrangements with its many affiliate physicians precisely because it is the dominant HMO operating in its region. Not

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[4] Citing "abundant evidence in the record," the district court agreed with the jury that there was "direct evidence that defendants acted with the specific intent to restrict competition." (Pet. App. 33a.) For example, Marshfield openly acknowledged meeting on a regular basis with its neighboring "supposed competitors" to "plan" marketing and physician placement, restrict managed care offerings, limit physician recruitment, limit new services, set prices for services, and reach understandings on future acquisitions. (Pet. App. 36a, 47a-53a.)

[5] The jury's finding of this *per se* violation of Section 1 of the Sherman Act was *affirmed* by the Seventh Circuit. (Pet. App. 17a-19a.)

coincidentally, Security charges subscribers far above the usual competitive prices for HMO services in Wisconsin. (Pet. App. 33a, 36a; *see also* Tr. 1118-22; Tr. Exh. 11, 12, 13.) Indeed, the evidence showed that Security did not provide employers or employees with *any* savings over traditional indemnity insurance plans (*id.*), even though, as the Seventh Circuit acknowledged (Pet. App. 5a), one would ordinarily expect such a price differential because HMOs are not substitutes for traditional health-care plans: HMOs limit patients' choice of physicians and utilization of medical services, and must therefore charge less than traditional plans—everywhere except in Marshfield's territory. Security can charge these extraordinary prices only because Marshfield has effectively excluded other HMOs from the market. In fact, Marshfield's own internal documents acknowledged that if a new HMO entered the market, Security's prices would have to drop by twenty percent—in its own words, Security would no longer be able to "mark-up" prices. (Tr. 985; Tr. Exh. 1562.) Thus, there was every reason to conclude (as did the jury and the district court) that Security is charging a monopoly price and that Marshfield had engaged in actions that were anticompetitive and restraints of trade.

Petitioners brought this action, alleging that respondents had conspired and attempted to monopolize, and succeeded in monopolizing, HMO and physician services in north-central Wisconsin, in violation of Section 2 of the Sherman Act and the parallel Wisconsin antitrust statute. The complaint also alleged that respondents had contracted, combined and conspired with others in restraint of trade.

After a full trial on liability,[6] the jury returned special verdicts finding that plaintiffs had established a relevant market for HMO services, and that defendants were liable under each of the antitrust claims set forth above. (Pet. App. 21a, 74a-76a.) After the damages phase of the

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[6] The district court had earlier denied defendants' motion for summary judgment. 881 F. Supp. 1309 (W.D. Wis. 1994).

trial, the jury awarded Blue Cross $10,500,000 in actual damages and awarded Compcare $5,669,227. (*Id.*)

The district court then (1) denied respondents' motion for judgment as a matter of law in all respects, except with respect to the finding of attempted monopolization; (2) denied respondents' motion for a new trial on liability; (3) denied respondents' motion for a new trial on damages, conditioned upon petitioners' acceptance of a remittitur, and (4) entered an injunction. Petitioners accepted the remittitur, whereupon the district court entered judgment in favor of Compcare in the amount of $15,223,182 (after trebling), and in favor of Blue Cross in the amount of $1,784,649 (after trebling), plus costs and attorneys' fees. The district court's opinion carefully reviewed the trial record, finding there was ample evidence to support nearly all of the jury's findings. (Pet. App. 21a-63a.)

On appeal, respondents challenged the sufficiency of the evidence, but raised no objections to the jury instructions regarding the antitrust laws. The court of appeals affirmed the verdict and judgment as to respondents' liability for geographic market division but reversed the balance of the verdict and remanded for a new trial as to damages and for reformulation of injunctive relief. Although the court acknowledged that the defendants had "a monopoly market share of the HMO 'market' " (Pet. App. 12a), it held that HMOs do not constitute a market under Section 2 because consumers and physicians could consider other forms of medical services to be substitutes for HMOs. (Pet. App. 5a-7a, 10a.) Having failed to find monopoly power in a properly defined market, the court refused to consider evidence that respondents had engaged in a broad pattern of exclusionary practices and had garnered extraordinarily high profits. (Pet. App. 9a, 12a-13a.) As for the Section 1 claim, the court characterized MFN clauses in the affiliation agreements as a mechanism for lowering prices, "the sort of conduct that the antitrust laws seek to *encourage*" (Pet. App. 17a (emphasis added)); but it upheld the jury's

conclusion that Security had geographically divided markets to keep other HMOs out of its "territory." (Pet. App. 17a-19a.)

The court of appeals denied a petition for rehearing, supported by *amici* the United States and the Federal Trade Commission, and at the same time amended its initial slip opinion. (Pet. App. 64a-65a.)

REASONS FOR GRANTING THE WRIT

Petitioners presented compelling evidence that Marshfield and its wholly owned HMO unlawfully monopolized and unreasonably and anticompetitively excluded petitioners from the market for HMO services, thereby injuring petitioners and forcing consumers in north-central Wisconsin to pay substantially inflated prices. Although a properly instructed jury found that evidence persuasive, the Seventh Circuit felt free to overturn the verdicts because they did not square with the court's preconceptions about the laws of economics. Rigorous economic analysis does play an essential role in the application of the antitrust laws, but it is a tool that must be used with care. Economic laws, like laws passed by legislatures, must be applied to the actual facts of a case. A court's facility with economic analysis does not give it license to ignore the evidence (including expert economic testimony) offered at trial and accepted by a jury, in order to create a neat package that fits easily within a preconceived economic model. That is precisely what occurred here.

As this case vividly illustrates, appellate review driven by unyielding adherence to economic models can have harmful repercussions extending far beyond the participants in a particular case. The Seventh Circuit has decreed that, as a matter of economic (and now federal) law, there is no separate market for HMO services. (Pet. App. 3a-13a, 65a.) *This means that nothing done by an HMO to exclude competition from other HMOs can violate the monopolization prohibition in Section 2 of the Sherman Act, or related "Rule of Reason" components of Section 1.* Indeed, the court of appeals went so far

as to hold that the Sherman Act is not implicated even where, as here, a large physician-owned HMO enters into *de facto* exclusive contracts with nearly every physician in the region. (*See* Pet. App. 16a-17a.)

These holdings are a matter of major concern, because they rule out the application of the antitrust laws to prevent the very kinds of anticompetitive activity that economists have identified as a likely outgrowth of the ongoing changes in the structure of the health-care industry. *See, e.g.*, Jonathan B. Baker, *Vertical Restraints Among Hospitals, Physicians and Health Insurers That Raise Rivals' Costs*, 14 Am. J.L. & Med. 147 (1988); Frances H. Miller, *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 Law & Contemp. Probs. 195 (1988). The Seventh Circuit's decision will now protect such conduct: it encourages existing physician groups and their HMOs to consolidate with one another at will and to sign *explicitly* exclusive agreements with other local physicians to keep out potential competitors; and it will stimulate the trend of physicians to create their own exclusive HMOs and limit the choices available to consumers. At a time when private market reform through "managed care" is becoming the wave of the future, it makes no sense to allow the structure of the health-care system to evolve in such anticompetitive directions based on economic theorizing that does not capture the reality of the marketplace. That is why we ask the Court to consider these issues *now*, rather than in some future case.

Remarkably, the Seventh Circuit adhered to its sweeping decision despite full awareness of its potentially broad effects. An *amicus* brief filed by the United States and the FTC in support of rehearing expressed serious concern that, at a time when "[h]ealth care markets are evolving rapidly," the decision might be interpreted as establishing a "rule of general applicability" that HMOs are not a market and that affiliation agreements with MFN clauses are not anticompetitive. Br. Amicus Curiae of the U.S. and FTC, at 4-9 (filed Oct. 2, 1995) (reprinted at Pet.

App. 66a, 68a-72a).[7] But the court's only response, in its order *denying* rehearing, was to make four limited changes in the text of the opinion that did not, by any stretch of the imagination, limit the impact of the case to its facts. (Pet. App. 65a.) This case thus warrants review because it still threatens to produce the very harms the United States and the FTC predicted.

I. THE SEVENTH CIRCUIT'S KEY RULINGS CONSTITUTE BROADLY APPLICABLE GENERALIZATIONS ABOUT THE ECONOMICS OF THE HEALTH-CARE SYSTEM NOT LIMITED TO A PARTICULAR FACTUAL CONTEXT.

The Seventh Circuit's key rulings—that HMOs do not constitute a separate market and that the contractual and other relationships between Marshfield and other health-care providers cannot be viewed as anticompetitive—were based on economic generalizations rather than record evidence. If left undisturbed, these generalizations will have a broad negative impact. This was true when the court of appeals issued its original decision, prompting the United States and the FTC to urge the court to limit the breadth of its holdings. And it is no less true now that the court of appeals has responded with *pro forma* qualifying language without otherwise altering its analysis of economic "realities" in the health-care field.

Turning first to the Seventh Circuit's holding that "HMOs are not a market" (Pet. App. 10a, 65a), there is nothing in the court's analysis to suggest that this conclusion is limited to a particular time, place, or trial record. The court asserted:

> The record shows, what is anyway well known, that individuals, and their employers, and medical insurers (the real "buyers" of medical services, according to the plaintiffs) regard HMOs as competitive not only with each other but also with the various types of fee-for-service provider, including "preferred

[7] The Government took no position on whether the trial record in this case supported the jury's verdict. (Pet. App. 68a, 72a-73a.)

> provider" plans (generally referred to as "PPOs," for "preferred provider organization") . . . .

(Pet. App. 5a.)[8] Based on this assertion, the court concluded that the "price that an HMO can charge is constrained not only by competition from other HMOs but also by competition from [other] forms of medical-services contracting" and, thus, that HMOs *in general* share a market with traditional health insurance products. (Pet. App. 5a-7a.) One searches these pronouncements in vain for any citation to the trial record, much less a demonstration that this particular record precluded a rational trier of fact from reaching a different conclusion. This general approach thus stands in sharp contrast to the district court's opinion which, based on specific reference to expert testimony, federal law, state law, regulations, employee programs, consumer preferences, history, and all manner of other evidence, concluded that the jury properly found that "an HMO is a distinct and unique form of health care financing for which a relevant product market exists." (Pet. App. 24a.)

The circuit court's conclusion that the contractual arrangements between Marshfield's HMO and the 900 other physicians in the region are not anticompetitive is equally broad in its potential impact. The court simply noted that these contracts with physician competitors do not *expressly* "forbid [the competitors] to join other HMOs or otherwise compete with Security or with the Marshfield Clinic" (Pet. App. 7a),[9] and then relied on the un-

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[8] Unlike HMOs—which are characterized by the use of a gatekeeper, aggressively managed care through risk sharing, and preventive medicine (Pet. App. 24a)—PPOs are simply a form of traditional fee-for-service health insurance under which "the insurer offers more generous reimbursement if the insured patronizes physicians who have contracts with the insurer to provide service at low cost to its insureds." (Pet. App. 5a.)

[9] The U.S. Department of Justice and the FTC "determine whether a physician network venture is exclusive or non-exclusive by its and its members' activities and not simply by the terms of the contractual relationship." DOJ and FTC Statements of Enforcement Policy and Analytical Principles Relating to Health

supported generalization that MFN clauses "are standard devices by which buyers try to bargain for low prices" and thus are "the sort of conduct that the antitrust laws seek to encourage." (Pet. App. 17a.) The court saw no need even to consider whether the contracts might be vehicles for tacit collusion as to price levels or refusals to deal.

Nothing of substance was changed after the Justice Department and the FTC filed their *amicus* brief and the Seventh Circuit made four perfunctory amendments to its opinion. (Pet. App. 65a.) With respect to the HMO market issue, although the court now admits the theoretical possibility that other types of HMOs and PPOs existing elsewhere "may vary in respects crucial to antitrust liability" (*id.*), there is no discussion of the particular features of the Security HMO or traditional health insurance plans available in north-central Wisconsin that could provide a basis for distinguishing this case in the future. The court's reasoning remains entirely generic and universal and entirely ungrounded in the trial record. Similarly, although the court now says that "[p]erhaps . . . [MFN] clauses are misused to anticompetitive ends in some cases" (*id.*), one is left to wonder how, in some future case, the evidence of such misuse could be stronger than it was here, where the court of appeals nevertheless held that no rational jury could have found an anticompetitive effect.

For these reasons, the opinion, fairly read, leaves lower courts in future cases with no basis for distinguishing, or escaping from, the Seventh Circuit's views of the generally applicable laws of economics.

Care and Antitrust, 4 Trade Reg. Rep. (CCH) ¶ 13,152, at 20,788, 20,796-97 (Sept. 29, 1994). The district court cited evidence of the type of contracts involved, expectations about patient referrals (including referrals of non-HMO patients), fee schedule approval, and market allocations to find that the "express" language was a facade. (Pet. App. 31a-33a, 36a-37a.) The court of appeals did not dispute any of this evidence.

II. THE SEVENTH CIRCUIT'S RULINGS ARE WRONG, BOTH AS A GENERAL MATTER AND AS APPLIED TO THIS CASE.

The Seventh Circuit's generalizations about the nature of economic reality, far from being truisms, are dubious as a general matter and flatly incorrect as applied to the facts of this case. There is every reason to conclude that HMO services can constitute a relevant market and that HMO affiliation agreements of the kind at issue here, with express MFN clauses and buttressed by other predatory and conspiratorial conduct, can have the purpose and effect of substantially lessening competition among physicians and among HMOs. Indeed, the evidence presented in this case—evidence the court of appeals largely disregarded—demonstrates that the Seventh Circuit's dogmatic generalizations based on preconceived economic theories do not hold water at all times and in all places. At the very least, that evidence makes it clear that the court of appeals had no basis for second-guessing the jury's resolution of these issues.

1. *The HMO Market Issue.* Market definition in an antitrust case is an intensely fact-based undertaking, requiring consideration of a variety of relevant factors. *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 481-82 (1992); *Brown Shoe Co. v. United States*, 370 U.S. 294, 325-28 (1962). The question whether a particular market exists is ultimately as much a question of consumer perception as of economic modeling. The issue is whether theoretical alternatives are such good substitutes that an attempted price increase above the competitive level would cause enough consumers to switch or enough other suppliers to enter and drive the price back down. An attempted price increase will be profitable if enough consumers perceive such distinct qualities in a product that they will continue to purchase it at the supracompetitive price rather than switching to possible alternatives, and if new providers are unable or unwilling to meet consumer demand at a lower price. (Pet. App. 69a-70a & 70a n.1.) *See United States v.*

Grinnell Corp., 384 U.S. 563, 571-72 (1966). Thus, the mere fact that HMOs face *some* competition from other forms of health-care delivery cannot be dispositive; unless that competition is strong enough to constrain HMOs from raising their prices significantly above competitive levels, there is still a separate product market for HMO services. *See U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 599 (1st Cir. 1993) ("Here, the issue for an economist would be whether a sole supplier of HMO services . . . could raise price far enough over cost, and for a long enough period, to enjoy monopoly profits.").

This Court has pointed to a number of "practical indicia" of market definition: "industry or public recognition of the [market] as a separate economic entity, the product's peculiar characteristics and uses, unique production facilities, distinct customers, distinct prices, sensitivity to price changes, and specialized vendors." *Brown Shoe*, 370 U.S. at 325; *see U.S. Healthcare*, 986 F.2d at 599 ("[u]sage patterns, customer surveys, actual profit levels, comparison of features, ease of entry, and many other facts are pertinent in" deciding whether there is a separate HMO market).[10]

Viewed from this perspective, it makes sense to treat HMOs and other forms of health-care delivery and financing as separate relevant markets. To begin with, consumers see these "products" as very different. (Pet. App. 23a-24a.) The Seventh Circuit itself emphasized this

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[10] By relying on abstract, neoclassical economic models supposedly subsumed within "contemporary principles of antitrust" (Pet. App. 3a), rather than on *Brown Shoe*'s "practical indicia" for market definition, the Seventh Circuit also contradicted precedents from its sister circuits. *See, e.g., United States Anchor Mfg., Inc. v. Rule Indus., Inc.*, 7 F.3d 986, 995 (11th Cir. 1993) (applying *Brown Shoe*'s "practical indicia"), *cert. denied*, 114 S. Ct. 2710 (1994); *Olin Corp. v. FTC*, 986 F.2d 1295, 1298-99 (9th Cir. 1993) (same), *cert. denied*, 114 S. Ct. 1051 (1994); *Fineman v. Armstrong World Indus., Inc.*, 980 F.2d 171, 199 (3d Cir. 1992) (same), *cert. denied*, 113 S. Ct. 1285 (1993); *H.J., Inc. v. International Tel. & Tel. Corp.*, 867 F.2d 1531, 1540 (8th Cir. 1989) (same).

point: the particular structure of an HMO (*i.e.*, payment of a flat rate for a year's medical care) has "consequences both for the practice of medicine and for the allocation of the risk of medical expenses." (Pet. App. 3a.) "Many people don't like [HMOs] because of the restriction on the patient's choice of doctors or because they fear that HMOs skimp on service since . . . the marginal revenue of a medical procedure to an HMO is zero." (Pet. App. 5a.) But HMOs have desirable features as well: they guarantee all needed care for a fixed sum (Pet. App. 3a-4a), and they minimize or eliminate paperwork. This distinctive mix of benefits and burdens is appealing to some consumers, even if it is unappealing to others. HMOs also are controlled under entirely separate state and federal regulatory schemes (Pet. App. 23a-24a; Tr. 62, 1111, 2310; Tr. Exh. 4; *see also* 42 U.S.C. § 300e-9; Wis. Stat. § 609.96)—a factor this Court has seen as indicative of a separate market. *See United States v. Connecticut Nat'l Bank*, 418 U.S. 656, 660-66 (1974).

This case illustrates the "practical indicia" that might reasonably lead one to conclude that, in a given region (such as north-central Wisconsin), other forms of health-care financing are not such close substitutes that a sole provider of HMO services would lack the ability to garner monopoly profits. To begin with, although the Seventh Circuit concluded that HMO prices are "constrained" by competition from traditional health insurance plans, Security *itself* admitted that it could charge monopoly prices as long as it was the only *HMO* operating in the region and the only "competition" it faced was other types of health plans. (Tr. Exh. 1562, 1563.) Security's internal documents estimate that its prices were twenty percent higher than it could charge if an HMO competitor entered the market. (*Id.*) Yet, while still charging that higher price, Security maintained a group of 70,000 subscribers who did not opt instead for more traditional insurance.

Moreover, Security's recognition that there is a separate HMO market in the region is confirmed not only by its own pricing strategy but also by the fact that its other exclusionary acts and agreements were aimed at preventing competition *from HMOs*, not from traditional health insurance plans. For example, Security agreed to a geographic market division with another HMO (NCHPP) operating in two nearby counties (Pet. App. 17a-19a, 36a-37a, 48a-49a; *see also* Tr. 856-57, 865-66, 870-71; Tr. Exhs. 1177, 1123, 1481), and it had express agreements with some of its affiliates that they would not work with any other HMO. (Pet. App. 36a-37a, 48a-49a; Tr. 712-13, 856-57, 865-71, 1361-62.)[11] If Security believed it would be forced by competition from PPOs or other forms of insurance to charge a competitive price, there would have been little point in entering into HMO-specific market-division agreements.

Another important market-determining factor is state and federal regulatory laws that preclude other types of health plans from substituting for HMOs. These laws require certain employers to offer their employees a separate HMO option. (Pet. App. 23a-24a.)[12] But Security is the only HMO option in north-central Wisconsin. (Pet. App. 23a.) As a result of these laws, when large em-

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[11] The administrator of Rhinelander Medical Center ("RMC") acknowledged at trial that Marshfield asked the RMC physicians not to participate in NCHPP—another HMO with which Security had divided the market. (Pet. App. 49a; Tr. 712-13.) The RMC physicians then dropped participation in NCHPP. (*Id.*)

[12] HMOs are required to be made available by certain large private employers and by state and local governments whenever feasible. 42 U.S.C. § 300e-9. Similarly, the federal government authorizes Medicare beneficiaries to receive their benefits through HMOs that contract with the Health Care Financing Administration. *Id.* § 1395mm; 42 C.F.R. § 417.420. Wisconsin, in particular, has created a comprehensive legislative package to treat HMOs as a distinct product. Wisconsin law provides that the Wisconsin Department of Health and Social Services may contract with HMOs to provide health benefits to beneficiaries of medical assistance, Wis. Stat. § 49.45(9), and creates distinct HMO capital and other requirements, *id.* § 609.96.

ployers are selecting health plans to offer to their employees, there is *no* competition between Security and traditional health insurance plans. Security can extract a monopoly profit without fear that employers will not offer Security's plan.[13]

The court of appeals also opines that the absence of barriers to entry precludes treating HMO services as a separate market. (Pet. App. 6a-7a.) But this reasoning begs the question, because barriers to entry are what this case is all about.[14] Petitioners, after all, attempted to create a competing HMO in the region, but were unable to do so because of exclusionary conduct by Marshfield and Security and its affiliated physicians. (Pet. App. 27a-28a.) An "HMO must be able to line up enough physicians with whom to contract to provide its subscribers with a more or less complete menu of medical services." (Pet. App. 4a.)[15] In this sense, the question of market definition in this case is closely linked with the second major issue on which the Seventh Circuit overruled the

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[13] There may still be some price competition between Security and traditional insurance when *employees* are selecting among plans that are offered. But that will only be true where employers require employees to pay part of the cost of their health coverage *and* these employee contributions are tied directly to the price paid by the employer.

[14] These are not barriers based only on economic theory. Rather, they are barriers created by real-life monopolistic and conspiratorial conduct by Marshfield and Security. (*See* Pet. App. 27a-28a, 31a-33a.)

[15] For this reason, the Seventh Circuit's discussion of PPOs is entirely incorrect. Because HMO enrollees are *required* to seek care from an HMO doctor, the HMO *must* have a complete array of providers. Without a complete array, the HMO could not be sold—as the court recognized. (Pet. App. 4a.) The patient in a PPO, by contrast, is free to go to any doctor. If, for example, his insurer's PPO lacks a nearby eye doctor, he can go to a non-PPO physician instead and still be covered by his insurance. The Seventh Circuit's reasoning that, because Blue Cross had a small PPO in part of the area, it could also establish a competing HMO (Pet. App. 6a) is a *non sequitur* because a PPO does not require a comprehensive array of providers, whereas an HMO does.

factfinder—*i.e.*, whether the affiliation agreements effectively blocked access to Security's affiliated physicians by a competing HMO. See pages 18-21 below.

The Seventh Circuit did not bother with any of these facts. It simply looked at the issue of market definition at an abstract level, and concluded that HMOs always face enough competition or potential competition to preclude viewing them as a separate market. Because of these preconceptions, it saw no need to take into account the actual evidence in the record that led a rational jury to conclude that HMO services, at least in north-central Wisconsin, do constitute a separate market.[16] That ruling effectively strips factfinders—whether judge or jury—of the discretion they must have if the antitrust laws are to retain sufficient flexibility to respond to complex and changing market conditions.

2. *The Issue of the Affiliation Agreements and Related Actions Aimed at Precluding HMO Access to Independent Physicians.* The situation is much the same with respect to the Seventh Circuit's holding that the Security affiliation agreements are not anticompetitive. Here again, the record considered by the jury contained ample evidence that the affiliation agreements function like exclusive contracts, establishing artificial price floors and making the affiliates effectively unavailable to other HMO entrants. (Pet. App. 36a-37a.) Moreover, that record demonstrated that Marshfield used other tactics, such as denial of staff privileges, refusal to cross cover, and selective acquisition of clinics in order to threaten or eliminate

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[16] *Compare* Louis Kaplow, *The Accuracy of Traditional Market Power Analysis and a Direct Adjustment Alternative*, 95 Harv. L. Rev. 1817, 1827 (1982) (criticizing then-Professor Posner's approach to market definition because "it forces an all-or-nothing framework on an issue that is in fact a question of degree"); *see also id.* at 1818 ("Combining markets to deal with problems of market definition [as Professor Posner recommends] . . . generally will lead one to understate market power, and the degree of understatement in many contexts will be substantial.")

competitors (*see* Pet. App. 13a, 31a-33a)—all designed to keep physicians within the Marshfield fold.

Yet the Seventh Circuit dismissed concerns about the agreements themselves based on its view that MFN clauses are always pro-competitive. (Pet. App. 16a-17a.) And, almost as an aside, it expressed skepticism that Marshfield's other actions toward independent physicians are "exclusionary in an invidious sense." (Pet. App. 13a.) It did so based on the conclusion that such practices are "ambiguous from the standpoint of competition and efficiency." (*Id.*)

This will not do. First, regardless of how MFN clauses may operate in other contexts, there was ample evidence that the affiliation agreements here had the purpose and effect of barring competition. Marshfield pays physicians signing up with its Security Health Plan at a rate well above what is paid by any conventional HMO and then recoups that amount from consumers by charging rates well above those charged by HMOs elsewhere in Wisconsin.[17] The use of MFN clauses within those agreements is essential to maintain anticompetitive pricing because it means that such affiliated physicians cannot sign up with another HMO at the discounted price usually paid by an HMO without simultaneously forfeiting the benefits of the Security full-fee payments. In substance, Marshfield through Security gave the affiliates a share of its monopoly profits, conditioned on the affiliate not giving any competing HMO a better deal. Moreover, the agreements were shown to amount to tacit acceptance of the affiliates into the Marshfield family, which produced the collateral benefit of avoiding direct competition from Marshfield, while maintaining cooperative relationships with other area physicians and hospitals. (*See* Pet. App. 31a-33a.) *See also* 6 Phillip E. Areeda, *Antitrust Law*

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[17] At trial, it was *undisputed* that Security's prices far exceeded those charged by other Wisconsin HMOs and exceeded the highest comparable state and federal HMO programs by 15% to 75%. (Tr. 1119-22.)

§ 1435e, at 229-31 (1986) (an MFN clause may be an unreasonable restraint of trade under Section 1 when it "facilitate[s] tacit price coordination" and "restrain[s] the seller's freedom of action in other transactions").

The Seventh Circuit had no basis for disregarding these facts. Indeed, commentators have also noted the anticompetitive effects of MFN clauses in comparable circumstances, as well as the potential for tacit collusion through the vehicle of an HMO. *See, e.g.*, Baker, *supra*, at 167-68 ("The most favored nations clause may have deterred cheating on a physician cartel, thereby facilitating collusion among doctors, by making it uneconomic for physicians to lower their fees to those patients participating in the HMO."); Miller, *supra*, at 235 ("In the long run, managed care vertical restraints imposed by dominant insurers and designed primarily to exclude prepaid plan competitors—rather than to produce more efficient service—could injure competition in both health services and health insurance markets."). The Seventh Circuit's approach disdained all of these not-so-subtle market realities, and generically endorsed MFN clauses without even a hint about the circumstances that might render them anticompetitive. (Pet. App. 17a ("standard devices").)[18]

This almost cavalier approach is even more amazing in light of the evidence that truly independent physicians were punished by Marshfield. (Pet. App. 31a, 33a, 50a-52a.) The Seventh Circuit did not dispute that evidence.

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[18] In referring to Judge Posner's "Chicago School" philosophy in a different case, one respected commentator noted: "[W]hen a court dismisses an antitrust complaint about a vertical restraint by saying that 'restricted dealing is a way to compete,' . . . it has substituted rhetoric for argument. Those are very well chosen words. They are both conclusive and expansive—but they prove nothing in themselves and are not a description of exhaustive empirical work verifying an hypothesis; in fact, they are nothing more than an expression of one opinion about the competitive effects of vertical restraints." Herbert Hovenkamp, *Rhetoric and Skepticism in Antitrust Argument*, 84 Mich. L. Rev. 1721, 1721-22 (1986) (footnote omitted).

(*See* Pet. App. 13a.) Yet it failed even to consider it in evaluating the effects of the affiliation agreements themselves. (Pet. App. 16a-17a.) And it went on to say that the jury was wrong to attribute significance to this conduct because its anticompetitive nature was "ambiguous." (Pet. App. 13a.)

If there was "ambiguity," of course, it was up to the finder of fact to weigh all of the circumstances and determine whether the conduct was anticompetitive. That is what the jury did here. And the proper model for judicial review of such a determination is the opinion of the district court, which reviewed all of the evidence and gave appropriate deference to the finder of fact. The Seventh Circuit's standard is a clear departure from that mandated approach.

In sum, this case illustrates the wisdom of the admonition, in the Government's *amicus* brief filed in the court below, that courts should "avoid any temptation to substitute reliance on generalizations or assumptions about the functioning of health care markets for careful analysis of the evidence presented in a particular case." (Pet. App. 69a.) The Seventh Circuit's "generalizations or assumptions" cannot be squared with the actual circumstances presented in this case. They should not be left in place as judicially endorsed rules of (economic) law that will bind lower courts in future disputes.

More generally, this decision typifies the dangers of an all-too-common tendency (especially among appellate judges) to espouse *rules* of *non*liability intended to minimize "false positives" (*i.e.*, legal prohibitions of conduct that is not anticompetitive)—even at the risk of repeated "false negatives" (*i.e.*, immunity from antitrust liability for anticompetitive conduct). *See* Frank H. Easterbrook, *Workable Antitrust Policy*, 84 Mich. L. Rev. 1696, 1701, 1706 (1986).[19]

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[19] This attitude is often associated with the "Chicago School" of antitrust analysis. *See* Lawrence A. Sullivan, *Post-Chicago Economics: Economists, Lawyers, Judges, and Enforcement Officials*

This Court has recently admonished against "per se rules of nonliability" based purely on "theoretical and legal arguments": "when the realities of the market and the record facts" indicate that anticompetitive effects have occurred, "theory will not stand in the way of liability." *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 113 S. Ct. 2578, 2591 (1993) (citing *Kodak*, *supra*). Recent scholarship by leaders of the "Post-Chicago School" of antitrust analysis has confirmed that careful factual investigation may provide "anticompetitive explanations for behavior regarded by Chicago scholars as unambiguously efficient."[20] *See Kodak*, 504 U.S. at 473-79 (citing and applying the work of leading Post-Chicagoans). Of particular relevance to the present case, these critiques have convincingly challenged (1) overly simplistic methods of defining markets and measuring market power;[21] (2) the thesis that competition is never harmed by exclusive dealing arrangements;[22] and (3) the

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in a Less Determinate Theoretical World, 63 Antitrust L.J. 669, 670 (1995) ("Chicago analysts who focus on antitrust tend both to start and stop with deductive analysis based on a sequence of truisms expressed through highly abstracted models of reality.").

[20] Michael S. Jacobs, *An Essay on the Normative Foundations of Antitrust Economics*, 74 N.C. L. Rev. 219, 241 (1995). *See generally Symposium on Post-Chicago Economics*, 63 Antitrust L.J. 445-695 (1995); Ian Ayres, *Playing Games with the Law*, 42 Stan. L. Rev. 1291 (1990).

[21] *Compare* William A. Landes & Richard A. Posner, *Market Power in Antitrust Cases*, 94 Harv. L. Rev. 937 (1981) *with* Kaplow, *supra* (criticizing Landes and Posner's approach to market definition) *and* Jonathan B. Baker & Timothy F. Bresnahan, *Empirical Methods of Identifying and Measuring Market Power*, 61 Antitrust L.J. 3 (1992) (advocating new econometric techniques for the direct measurement of market power).

[22] *Compare* Richard A. Posner, *Antitrust Law: An Economic Perspective* 203-04 (1976) *and* Robert H. Bork, *The Antitrust Paradox: A Policy at War with Itself* 138-42, 262, 304, 309 (2d ed. 1993) *with* Joseph F. Brodley & Ching-to Albert Ma, *Contract Penalties, Monopolizing Strategies, and Antitrust Policy*, 45 Stan. L. Rev. 1161, 1163 (1993) *and* Thomas G. Krattenmaker & Steven C. Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power over Price*, 96 Yale L.J. 209 (1986).

notion that MFN clauses that raise potential rivals' costs cannot constitute barriers to entry.[23]

The Seventh Circuit's ruling in this case is a paradigmatic example of the attitudes and approaches that have come under severe criticism in the scholarship of the Post-Chicagoans. But the Sherman Act no more embodies the Chicago School's version of neoclassical price theory than the Fourteenth Amendment "enact[s] Mr. Herbert Spencer's Social Statics." *Lochner v. New York*, 198 U.S. 45, 75 (1905) (Holmes, J., dissenting).

III. THESE RULINGS WARRANT REVIEW BECAUSE OF THEIR POTENTIAL IMPACT ON THE FUTURE SHAPE OF THE HEALTH-CARE SYSTEM.

The Court should seize the opportunity to review the issues raised here *now*. To begin with, because the Seventh Circuit spoke in such broadly applicable terms, and because there is a full trial record, this case presents a clean and appropriate vehicle for clarifying how antitrust principles should apply in this context. Moreover, such clarification is vitally important *today* because there is an ongoing shift toward HMOs and other forms of managed care that will soon be accelerated by federal legislation. If the decision below is allowed to stand, HMOs such as Security not only will profit enormously at the expense of medical consumers, but they also will be allowed permanently to consolidate their monopolies over HMO services at a time when the HMO sector is poised to become the dominant force in American health care.

Enrollment in HMOs has soared from 2 million in 1970 to 20 million in 1985 and more than 51 million today.[24] HMO enrollment will accelerate further in the

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[23] *Compare* Easterbrook, *Workable Antitrust Policy*, *supra*, at 1710 *with* Baker, *supra and* Arnold Celnicker, *A Competitive Analysis of Most Favored Nations Clauses in Contracts Between Health Care Providers and Insurers*, 69 N.C. L. Rev. 863 (1991).

[24] Steven Findlay, *Will Big HMOs Stamp Out Competition?*, Business & Health, Oct. 1995, at 52; Sheldon Greenfield et al., *Outcomes of Patients with Hypertension and Non-insulin-dependent*

late 1990s, as private market competition increases and the government continues to embrace HMOs as a new method for delivering publicly funded medical care. At least 46 states have enacted legislation directed at HMOs. Jon B. Christianson et al., *The HMO Industry: Evolution in Population Demographics and Market Structures*, 48 Med. Care Rev. 3, 29 (1991). And both the federal and state governments have turned increasingly to HMOs as a potentially efficient method of health-care delivery in Medicare, Medicaid, and employee programs.

Indeed, while the debates over health-care reform in 1994 and the balanced budget in 1995 and early 1996 have often been divisive, at least one point of consensus has crystallized: managed care, including HMOs, will play an increasingly central role in American health care for the remainder of this decade and on into the next century. Last summer, Congress enacted legislation to expand "Medicare Select"—which encourages senior citizens to join managed-care programs—from a fifteen-State experiment to a fifty-State permanent program. *See* Pub. L. No. 104-18 (1995). Moreover, the expanded use of HMOs by Medicare and Medicaid alike is central to the seven-year balanced-budget legislation that is currently being debated. For example, both the congressionally approved version of the balanced-budget bill and its Administration counterpart provide Medicare beneficiaries a variety of new options including coverage through HMOs and health plans organized by doctors and hospitals. *See* H.R. Rep. No. 350, 104th Cong., 1st Sess. (1995) (conference report to accompany H.R. 2491, the Balanced Budget Act of 1995, which was passed by the House and Senate in November 1995 and vetoed by the President on December 6, 1995); Health Provisions of President Clinton's Seven-Year Budget Plan, Health Care Pol'y Rep. (BNA Dec. 11, 1995).

Diabetes Mellitus Treated by Different Systems and Specialties: Results From the Medical Outcomes Study, 274 J. Am. Med. Ass'n 1436, 1436 (1995).

The bipartisan consensus favoring HMOs is founded on two assumptions. First, as an empirical matter, competition by managed-care organizations has reduced—and can continue to reduce—health-care costs throughout the Nation.[25] The fact that HMOs have *not* served this cost-containing function in north-central Wisconsin clearly highlights the risks of allowing any single HMO to obtain monopoly power within a geographic market.

Second, it is assumed that antitrust laws will continue to apply to the health-care industry with full vigor and effect. In the twenty years since this Court established in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), that professionals are subject to the same rules governing competitive behavior that apply to other businesses, *id.* at 786-88, federal antitrust law has played a critical role in eliminating barriers to competition among health-care providers and insurers. "Removal of these barriers effectively created an atmosphere in which innovative payment systems could flourish and providers could freely accept alternative practice and compensation agreements."[26] In the mid-1990s, those competing innovations and alternatives are receiving the imprimatur of Congress and the executive branch. If HMOs and other physician-owned networks are allowed to monopolize services in particular geographic markets just as the federal government grants them a privileged place in health-care policy, the damage will be serious, and may be irreversible. It has long been recognized that the accoutrements of monopoly include not only extraordinarily high profits,

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[25] *See* Congressional Budget Office, The Effects of Managed Care and Managed Competition (Aug. 22, 1995) (largely attributing 1994's relatively low rate of medical inflation to the increased use of managed care); U.S. General Accounting Office, Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs, GAO/HEHS-96-2 (Oct. 4, 1995); KPMG Peat Marwick LLP, Health Plans in 1995 (Sept. 1995) (HMO costs increased by only 0.4% in 1994, while medical inflation averaged 4.6% per year).

[26] Thomas L. Greaney, *When Politics and Law Collide: Why Health Care Reform Does Not Need Antitrust "Reform"*, 39 St. Louis L.J. 135, 137 (1994).

but also the ability to bar entry into the market by potential rivals. As Judge Learned Hand explained a half century ago, "immunity from competition is a narcotic, and rivalry is a stimulant, to industrial progress." *United States v. Aluminium Co. of America*, 148 F.2d 416, 427 (2d Cir. 1945). It makes no sense to insulate HMOs from antitrust scrutiny and thereby to allow monopolistic HMOs to consolidate their market power at the very moment when Congress is recognizing competition among HMOs as the primary stimulant to progress in the health-care industry.

This is particularly true in light of the fact that *physician-owned* HMOs (such as Security), which currently constitute only fifteen percent of all HMOs, are now the fastest growing sector within the HMO market.[27] The new Medicare provisions of the balanced-budget bill expressly preempt state regulatory systems that currently prevent physicians and hospitals from participating in the HMO market unless they meet that State's HMO insurance requirements.[28] As a result, in the next two years, tens of millions of Medicare beneficiaries may, for the first time, be able to choose physician-owned HMOs.[29]

In this context, the decision below presents two particularly disturbing problems. First, a serious consequence of the Seventh Circuit's refusal to recognize that HMOs can constitute a relevant product market is that no amount of consolidation of HMOs in a given region could violate

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[27] Mark D. Whitener, Deputy Director, Health Care Division, FTC, *Antitrust, Medicare Reform and Health Care Competition*, 1995 WL 714346 (F.T.C.), at *6 (remarks before the American Enterprise Institute) (Dec. 5, 1995).

[28] The preemption provision was added in order to gain the support of physicians' and hospitals' groups for the balanced-budget bill. *See* Robert A. Rosenblatt, *Doctors Prescribe Medicare HMOs as Panacea for Ailing Bottom Lines*, L.A. Times, Nov. 25, 1995, at A29.

[29] *See* Rosenblatt, *supra* note 28.

federal antitrust law.[20] This fear is not merely academic. In the last eight years, notwithstanding the remarkable rate of growth in demand for HMO services, the number of HMOs nationwide has *decreased* by more than fifteen percent. As one industry publication recently put it, HMOs have been "struck with bigness fever": 1994 witnessed thirteen HMO mergers and acquisitions, worth $4.0 billion, and the pace of HMO mergers picked up in 1995. Findlay, *Will Big HMOs Stamp Out Competition?*, *supra*, at 52. Not surprisingly, this concentration often comes at consumers' expense. *See* Douglas R. Wholey et al., *The Effect of Market Structure on HMO Premiums*, 14 J. Health Econ. 81, 101 (1995) ("The strongest conclusion from our research is that a larger number of HMOs in a market area is related to lower HMO premiums."). In Massachusetts, for example, where recent mergers have enabled three HMOs to capture roughly two-thirds of the HMO market—one of the highest levels of concentration in the country (outside of north-central Wisconsin)—HMO premiums run 20% to 25% above the national average. *See* Dan Wise, *Massachusetts: High Prices in a Managed Care Stronghold*, Business & Health, Oct. 1995, at 37.[21]

The Seventh Circuit did not stop, of course, with the HMO market. It then went on to hold that Security's

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[20] *Compare* Charles F. Rule, Assistant Attorney General, Antitrust Division, U.S. Dep't of Justice, Remarks Before the Group Health Ass'n of Am. (Feb. 28, 1989) (HMO controlling more than 35% of available providers and precluding them directly or indirectly through MFN clauses would pose antitrust problems).

[21] "[W]here there is not a competitive HMO system, prices are higher and access is limited. In northern Wisconsin, there is virtually one HMO and its rates have been documented as being well in excess of the state average. This area also has the highest uninsured rate in the state." *The Transformation of the Medicaid Program: Hearings Before the Subcomm. on Health and Environment of the House Comm. on Commerce*, 104th Cong., 1st Sess. (1995) (statement of Rep. Scott Klug); *see also supra* note 3. The uninsured rate in northern Wisconsin is 44% higher than the rest of the State. Wis. Dep't of Health and Social Servs., Ctr. for Health Stats., Report on the Uninsured and Insured, table 3 (1995).

absence of market power prevented the court from even considering *vertical* restraints that may violate the Sherman Act. (*See* Pet. App. 12a-13a.) Its decision would require courts to turn a blind eye toward business practices that would become commonplace if this decision stands. In particular, HMOs would have carte blanche (1) to raise the costs of rival HMOs by securing MFN agreements from "affiliated" physicians, (2) to refuse to allow participating physicians to "cross-cover" for non-affiliated physicians, (3) to prevent hospitals they control from joining other HMOs, and (4) to discriminatorily obstruct staff privileges at those hospitals.

These problems are compounded when physicians own HMOs, as physicians own Marshfield and Security. (Pet. App. 2a-3a.) This horizontal component increases the risk that arrangements with HMOs will do more to suppress competition among physicians than to increase consumer choice. *Compare Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982).

The importance of this case to the application of antitrust principles in health care was demonstrated, in part, by the scope of the *amicus* participation in the Seventh Circuit—reflecting both major physician associations (*e.g.*, the American Medical Association, the Medical Group Management Association, the American Group Practice Association, and the State Medical Society of Wisconsin) and representatives of national health insurers (*e.g.*, the Health Insurance Association of America and the Blue Cross Association). The legal, medical, and general press throughout the country has recognized that the issues squarely presented by *this case* represent the most important antitrust concerns in health care.[32] Be-

[32] Coverage and commentary on this case has included: Bradley G. Clary & Michel A. LaFond, *Antitrust and Integrated Delivery Systems*, Health L. Dig., Feb. 1995, at 3; *Wisconsin Antitrust Verdict Rattles Insurers and HMOs*, Bus. & Health, Feb. 1995, at 57; *Wisconsin Clinic Disputes Antitrust Ruling*, Mod. Healthcare, Apr. 3, 1995, at 6; *Blue Cross Prevails on Monopolization, § 1 Charges Against Marshfield Clinic, HMO*, Antitrust & Trade Reg.

cause prompt resolution of those issues is of vital importance to the ongoing national health-care debate, the Court should grant review of the petition.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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Rep. (BNA) No. 1707, at 443 (Apr. 6, 1995); *Wisconsin Blues Seek Second Verdict, This Time in the People's Court*, Mod. Healthcare, May 15, 1995, at 52; *Lack of HMO Market is Fatal Weakness, Marshfield Clinic Says in Appeals Brief*, Health L. Rep. (BNA) No. 4, at 1212 (Aug. 10, 1995); Thomas Campbell, *Market for HMO Services, Definition at Issue in Marshfield Appeal*, 2 Health Care Antitrust Man. No. 7, at 1 (Sept. 1995); *Blue Cross' Damages in Case Against Marshfield Clinic's HMO Must Be Retried*, Antitrust & Trade Reg. Rep. (BNA) No. 1730, at 331 (Sept. 21, 1995); *Rural Wisconsin Medical Clinic and Its HMO Did Not Monopolize*, Trade Reg. Rep. (CCH) No. 387, at 1 (Sept. 27, 1995); Mary Chris Jaklevic, *Feds Challenge Marshfield Ruling*, Mod. Healthcare, Oct. 9, 1995, at 33.